HISTORICAL REMARKS

ON THE

OPERATION OF OBLITERATING THE VAGINA BY UNITING ITS WALLS (KOLPOKLEISIS) FOR RE-ESTABLISHING CONTINENCE OF URINE IN CASES OF INCURABLE VESICO-VAGINAL FISTULA,

TOGETHER WITH A

STATEMENT CONCERNING THE PRESENT MODE OF OPERATION ON VESICO-VAGINAL FISTULÆ IN GERMANY.

BEING A REPLY BY

D^R. **Gustav Simon,**

PROFESSOR OF SURGERY AT THE UNIVERSITY OF HEIDELBERG
(FORMERLY AT ROSTOCK)

TO

D^R. **NATHAN BOZEMAN,** NEW-YORK.



Esteemed Colleague!

In No. 43 of the New-York Record, vol. II, 1867, in an article entitled „Vesico-vaginal and recto-vaginal fistula“ you raise claims of priority for the invention of the operation for the obliteration of the vagina by uniting its walls, which you performed for the first time in 1859 and the result of which you published in 1860, and you gave at the same time to be understood in an unmistakeable manner, that, in my work of the year 1862[1]), in which I have described several cases of that order, I had been guilty of plagiarism. In reply to that I forwarded to you my writings on the subject in question, requesting at the same time that you would revoke the charges you made against me as well as your claim of priority. Although this was done as far back as last spring, nearly 9 months ago, you have not yet thought proper to comply with my request; thus I found myself compelled in No. 45 and 46 of the „Deutsche Klinik“ to come forward publicly, and this translation I have since caused to be made.

In the said article, after recapitulating your own merits concerning the operation of vesico-vaginal fistules, among which you count the invention of Kolpokleisis, you continue in the following strain on page No. 435:

„In Germany, it is true, Prof. Simon, of Rostock, a few months before I performed my operation, proposed precisely the same procedure[1]), cross obliteration of the vagina (quere Obliteration der Scheide), and had actually performed the operation twice, though without any success. We have, therefore, no proof of his having ever effected a cure by his procedure prior to the date of my paper. But when we know the kind of cases in which Prof. Simon first proposed his operation, there will not be found such a willingness, I imagine, to award him the credit he might otherwise have been entitled to. He tells us that the case which suggested this novel procedure to him, was one in which the vagina was almost in a normal state, and the fistulous

[1]) Simon: Ueber die Heilung der Blasenscheidenfisteln durch die blutige Naht, nebst Bemerkungen über die Heilung der Fisteln, Spalten und Defecte, welche an anderen Körperstellen vorkommen. Rostock 1862.

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opening so small as only to admit the end of the finger, but is was deeply situated in the vagina and difficult to approach. These were the circumstances, after several attempts to close the small fistule, we are told, which called forth the above expedient and which fortunately proved equally unsuccessful. I say fortunately, because it was truly so to both patient and reputation of surgeon, for the latter tells us afterwards he succeeded in closing the same fistule and discharged the patient cured, a result to her infinitely preferable to that of an obliterated vagina, and certainly more in accordance with correct principles of surgery, all must admit. As appears from the date of Simon's article quoted, he did not publish his views until two years after mine appeared, but he makes no mention whatever of my case or operation. I should be disposed to attribute this oversight or neglect to the fact of his having not seen my papers, but the palpable injustice is made manifest by his resort to my plan of suture, and in the very case too upon which he first tried transverse obliteration of the vagina, and failed.

I will defer saying more at the present time in connection with this important operation, as I hope to be able soon to present my views upon it in a different form, and with suitable illustrations."

I need not dwell: in order to convince you of the absolute nullity of your pretensions to priority, and to show the inconsiderate manner in which you accuse me; on the extraordinary logic with which you claim the invention of an operation, which was however as you yourself admit, performed before your own, and in exactly the same way, although in a case as you think where it was not indicated. Nor will I prove, as I might, that in this case also the obliteration was perfectly justifiable at the time of the operation and that its failure is solely attributable to special causes mentioned in the description of the case[1]). All this I will pass over, and rest satisfied with

[1]) I take the liberty to give a short history of this interesting case, which also caused me to invent my instruments for better exposing fistules, to enable the readers to form an opinion whether the insinuations of Bozeman are justified.

The patient, Maria Birk of Wiesbaden (see my work of 1862, pag. 5) was afflicted with a vesico-vaginal fistula and a total prolapsus recti. The latter was exstirpated by means of the écrasenr; the wound healed and left a broad annular cicatrice in the rectum about 2 inches above the sphincter. The fistula (of the size of a cherry) was situated in the left side of the fornix of the vaginal cavity, could not be dislocated and was found to be so inaccessible, that, with the instruments then at my disposal, the operation was not reliable. Two attempts to unite the borders of the fistula having failed for these reasons, and violent Hæmorrhage as well as symptoms of Peritonitis having followed, I gave up the hope of healing the fistula itself and resolved upon performing Kolpokleisis to establish confinence of urine at all events. At the beginning of August and at the end of September 1858 I operated — each time on the pars urethralis of the vagina. But each time the united borders separated again. I thought the cause of these discouraging results, which had not presented themselves thus in my former operations, originated from the extirpation of the rectum by which the posterior wall of the vagina, which was used for the obliteration, was transformed into cicatrized tissue. This cause

stating, that previously to the case mentioned, and long before the year 1859, when you obliterated the vagina, I performed the same operation for the first time as far back as the year 1855, and that I had actually operated in the same manner four times with more or less success when you preferred your priority claims. If you had taken the trouble to look at my former writings on the subject, or to read with more care my work published in 1862, or to cast a glance over the German works on Surgery and Gynæcology, you would have abstained from these claims and spared yourself this rebuke.

My first publication on Kolpokleisis I made in 1856. In No. 35 of the „Deutsche Klinik" of that year two cases of that order were described under the title „Querverschluss der Scheide." In the year 1858 I published another article in the „Monatsschrift für Geburtskunde und Frauenkrankheiten," vol. XIII, Series II, in which I stated that I had performed Kolpokleisis five times; and that I had presented the previous year several of my patients at the meeting of the „Mittelrheinische Aerzte" and that two of the surgeons then present — Professors Wernher and Roser had operated since then according to my plan; the former with complete, the latter with only partial success. Annexed to the same article, you could have found illustrations representing the operation and its result in a case I operated on in June 2nd 1856 (Mrs. Mergenthaler — see „Deutsche Klinik" 1856, No. 35). To convince you and the readers of this paper of its success I give here the illustrations which accompanied that article. Fig. 3 shows the vagina closed, excepting a very small fistula; Fig. 1 the freshening and the sutures; Fig 2 the side view of the same; Fig. 3 the union of the parts, *N* the cicatrix, *F* the remaining little fistula; Fig. 4 the same (side view).

But not only in my works might you have found information; but as I stated above, all other German text- or hand-books of Surgery and Gynæcology would have offered you the same advantage. There you could have found that Kolpokleisis under the name „Querverschluss der Scheide" was described as my invention, long before you ever thought of performing it. As early as 1859 Mr. Mumm presented an inaugural thesis on Kolpokleisis to the medical faculty of the university of Marburg. After these statements I

I could not remove and I found myself therefore compelled to abandon the obliteration of the vagina. About that time I received Sims' speculum and his work on silver sutures (Silver sutures in surgery, New-York 1858) and thereupon I tried with the aid of these in the knee-elbow postnre, entirely according to Sims' directions to close the fistula. Yet also this trial was unsnccessful, because, although the fistula was exposed to the eye, it could not be made accessible to the instruments. I then constrncted for this patient the instruments, which are copied in my work of 1862 and which I have used, in all my operations of this kind, ever since. By their aid I succeeded to lay open the defect in such a manner that I could reach it, and by two operations in the reclining posture and by silk sutures its cnre was effected.

Fig. 1.

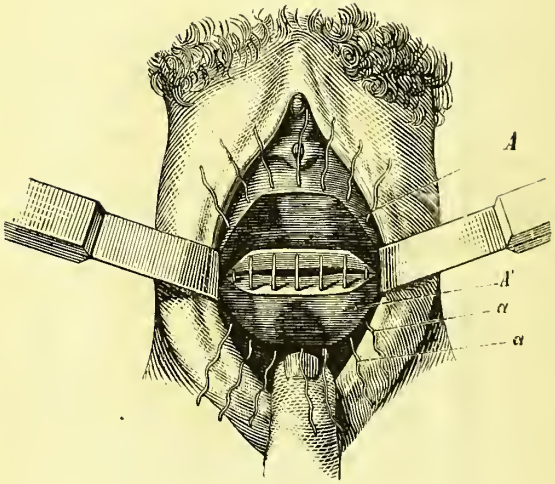


Fig. 2.

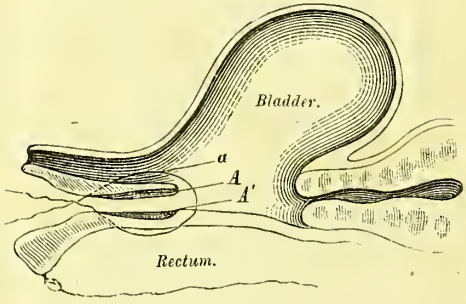


Fig. 3.

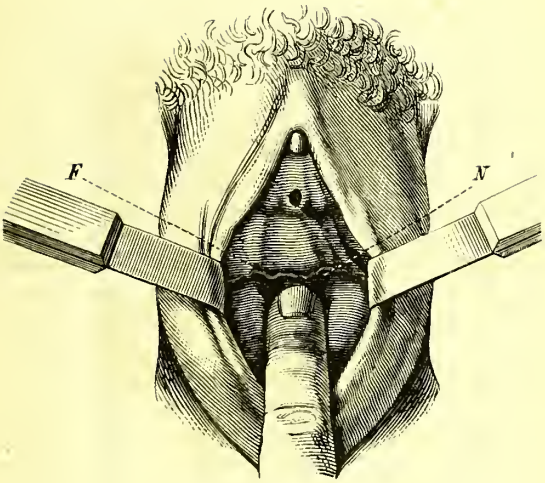
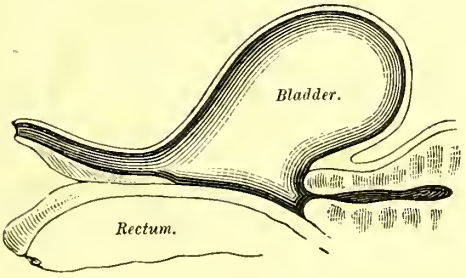


Fig. 4.



trust that you will abandon all claims of priority. I only add the request that you will recall the reproaches you made to me in the same Journal, in which you published them, and that in future you will study German literature more carefully, before you charge with plagiarism a German, who occupies a public position, and enjoys some consideration among his countrymen.

The reason, why I have proved the validity of my claims of priority at such length, is simply this, that in my opinion Kolpokleisis is the most important plastic operation which in the last decennia has originated from one single man. The operation of vesico-vaginal fistula by uniting the borders of the defect is indeed, in its present perfection and precision, a much more important acquisition than Kolpokleisis and probably the greatest achievement of our century in plastic surgery; but it has not been carried to that perfection by a single man, but on the contrary operators of all nations have contributed their share to it. The „Uranoplastic“ of our ingenious countryman — von Langenbeek — could alone be placed by the side of Kolpokleisis, as far as the safety of the performance and its immediate success are concerned. It would rank higher still on account of its more frequent occurrence, if its benefit for the voice in increasing its purity could be secured in all or in the majority of cases. But as in many cases this result is not obtained at all and in others only incompletely, Kolpokleisis must be considered the more important operation, as in all cases it fully answers its purpose. This operation which I invented at the time when the obliteration of the vulva, proposed by Vidal[1]), proved inefficacious in reestablishing continence of urine, has already been performed more than 50 times with complete success. Through it many patients with incurable defects of the bladder have been freed of the most intolerable suffering, viz. the incontinence of urine. I have myself succeeded in 18 cases in effecting perfect obliteration, and every German surgeon who practises the art of curing vesico-vaginal fistules, has recorded one or more successful cases of that kind. —

Since the invention of Kolpokleisis however I have not remained satisfied with that mode of operation, to which you still adhere. On the contrary,

[1]) Episio-Elytrorrhaphia for the obliteration of the vagina has been performed 8 or 9 times by French and German surgeons (twice by me), but in no case the obliteration has been fully attained. Dr. Schuppert of New-Orleans succeeded some time ago in effecting the perfect closure of the vagina by this operation; but even in this exceptional case of success the continence of urine was not perfectly reestablished. The fact, that the successful issues of this operation have been so few, that the danger is greater and that the normality of the parts is farther encroached upon by it than by Kolpokleisis, will probably cause surgeons to avoid it, even in very great defects, in which the obliteration is to be established in the lower part of the vagina. (See „Episiorrhaphy“ in my article „Operationen an den weiblichen Sexualorganen“ in the „Monatsschrift für Geburtskunde und Frauenkrankheiten“, vol. XIII, 1, 3, 4, 6.)

I have constantly laboured to perfect the method of operating; to multiply its chances of success, in the different parts of the vagina, and to render its indications more precise. Whereas I had, in my first cases, operated only in the lower parts of the vagina and had repeatedly met with small remaining fistules which could not be brought to heal, such occurrences are now extremely rare and I close, as the case may be, in any height of the vagina and always immediately below the defect. Nay in one case, where the fistule was high up in the fornix, I needed only one half of the latter for the obliteration, thus preserving the vagina in its whole length. (See my „Beiträge zur plastischen Chirurgie, Prag 1868, fol. 216). Moreover, whereas I used to consider Kolpokleisis indicated only where very large defects existed, I have now limited this indication a good deal, having cured at later periods very considerable defects by uniting the borders of the wound by sutures, like these (⌒, T, ⅄, T̄), by resorting to incisions along the sides and parallel with the sutures, and even by transplanting a flap from the vesico-vaginal wall. The size of a defect has, for the reasons enumerated, during the last 5 or 6 years not been in my eyes an indication for Kolpokleisis. On the other hand I have found, among the large number of difficult and complicated cases which have come under my treatment[1]), several in which it was either impossible, or too dangerous to unite the borders, so that here I resorted to Kolpokleisis.

So much for Kolpokleisis. I avail myself of this opportunity to present to you, esteemed colleague, and to your countrymen a statement of the growth and progress of the operation for vesico-vaginal fistules in Germany, as much on this subject may still be unknown to you. My statements will no doubt be for you — the most experienced operator on fistules in America — of the greatest interest, as you will thereby perceive, that the operation in question was fully practised in Germany, before you and Sims came forth with it in England and France; that in this country it has been carried to a simplicity, perfection and certainty of success, which it has not attained in any other country, and that especially your American method and its modifications have been surpassed in every respect. Without fear of contradiction I believe myself justified in considering, that of all surgeons I have been most extensively occupied with this operation, practically and theoretically, and have most promoted its perfection[2]). For this reason it will not

[1]) The large majority of the defects of the bladder, operated by me, were of a very difficult kind, because most of the patients came from distant parts of Germany and Russia, and their cure had either been unsuccessfully tried by other surgeons or abandoned beforehand. (Compare results of the operation in my „Beiträge zur plastischen Chirurgie," Prag 1868, fol. 141.)

[1]) My publications concerning this part of surgery are: 1) Ueber die Heilung der Blasenscheidenfisteln; Beurtheilung der „Opération autoplastique par glissement" von Jobert de Lamballe in Paris; neue Methode der Naht, die Doppelnaht (Entspannungs- und Vereinigungsnähte) zur Vereinigung der Fistelränder, Giessen 1854. — 2) Operationen bei Urinfisteln des Weibes; Deutsche Klinik 1856, No. 30, 31, 32, 33 und 35. — 3) Ueber die

seem extravagant to you, if I speak in the following more particularly of my method of operating and the success achieved thereby.

When (in 1858) you and afterwards Marion Sims — the inventor of the silver suture and of the duck bill speculum — succeeded in England and France in curing a number of vesico-vaginal fistules without the parallel incisions as proposed by Jobert, and simply by stretching the borders of the defect, you produced a real enthusiasm among the first authorities of those countries[1]). The silver suture, to which the happy results were attributed, and which was pronounced by the worthy but extremely enthusiastic Sims before the New-York academy of medicine: „The great surgical achievement of the 19th centnry," made the round throughout Europe. In Germany alone, we did not share in that enthusiasm, as numerous cures of fistules had been accomplished already by myself and other operators by the use of silk thread, and also by stretching the borders[2]); and as I had already established the principles of the operation, according to which its success does not depend upon the species of material used for the suture, but, as in all other plastic operations, upon the most careful scarification and equally careful uniting of the wounded edges[3]). Nevertheless I have made trials with the wire suture, simultaneously with fine sutures of other materials, principally with silk[4]), by way of experiment on animals as well as men, and I have resorted to it repeatedly in operations for vesico-vaginal fistules, cleft palates, harelip, ruptures of perineum etc. I have found that, far from being the conditio sine qua non of attaining the healing by first intention, (as Sims believed) it possesses no advantage what-

Heilung der Blasenscheiden- und Blasen-Mutterfisteln; Monatsschrift für Geburtskunde und Frauenkrankheiten, Berlin, Bd. XII, Heft 1, 1858. — 4) Bericht über 9 Fälle von Operationen der Blasen-Scheiden- und Blasen-Mutter-Scheidenfisteln, mit epikritischen Bemerkungen; Scanzoni's Beiträge, Würzburg 1860, Bd. IV. — 5) Ueber die Harnleiter-Scheidenfisteln; Scanzoni's Beiträge, Bd. IV. — 6) Ueber die Operation der Blasen-Scheidenfisteln durch die blutige Naht, mit Bemerkungen über die Heilung der Fisteln, Spalten und Defecte, welche an anderen Körperstellen vorkommen; Rostock 1862. — 7) Beiträge zur plastischen Chirurgie, vorzugsweise zu den plastischen Operationen an den Wandungen der zugängigen Körperhöhlen; des Mundes, der Scheide und des Mastdarms; Prag 1868.

[1]) In England at that time the operation for vesico-vaginal fistula was very little cultivated and in France only the imperfect method of Jobert „par glissement" was used.

[2]) Dieffenbach and Wutzer effected a few cures as far back as 1830—40. Then followed, dating from 1852, a number of happy results which increased every year in proportion with the increase of operaters. Dr. Tenner (1852), myself (1854, 1856 and 1858), Reser (1854), Esmarch (1857), all have made their publications on that subject previous to Bezeman's voyage. Afterwards joined us Ulrich, Wilms, Wagner of Königsberg, Spiegelberg, Hegar and others.

[3]) See my works of 1854 and 1858.

[4]) See my work: „Ueber die Heilung der Blasenscheidenfisteln," Rosteck 1862, pag. 89 und 122, and my „Beiträge zur plastischen Chirurgie" etc., Prag 1868, pag. 38.

ever over fine silk thread[1]), but on the contrary makes the operation more difficult and prolongs it unnecessarily. Therefore I declared the wire suture in my work of the year 1862, (see pag. 88) to be a transient object of fashion notwithstanding the overflowing praise, which the American, English and French authorities bestowed upon it. Considering the difficulty of its application and removal I do not look upon it as a progress. On the contrary, I view it as a backward step and I entertain no doubt, that, at a time not far distant, the wire will have to yield to the more handy fine silk thread suture, such as I use in the above mentioned plastic operations[2]).

The only thing I have welcomed as a real progress in the much praised American or Sims' method[3]), is the introduction of the duck bill speculum, in as much as it facilitates the exactness of the operation more than all previously invented instruments. But even this I soon found to be insufficient in cases of difficult access, (as in the one described above) and I therefore constructed in addition to the above speculum, which I provided with a long handle, flat specula and so-called „vagina holders" for the expansion, and at the same time for the shortening of the vagina[4]). Instead of the knee-elbow or the side posture, which Sims prefers, I make use of the one generally resorted to in the operation for stone in the bladder with the pelvis somewhat more elevated (Steiss-Rückenlage), which admits enlarging and shortening of the vagina and is less fatiguing to the patient (See Fig. I in my work of 1862). Instead of the very large flat-oblique („flach-schräg") freshening of the mucous membrane of the vagina of a width upwards to 2 Centim., I make the excision of the borders more steep-oblique („steil-schräg") and from 1 to $1^1/_4$ Centim. wide and carry

[1]) I use for fistules and similar plastic operations the so-called Chinese silk, which I receive from Mr. Schliemann, instrument-maker at Hamburg. The finest kind, which is finer than the finest silver wire, I use as double thread.

[2]) To prevent my being misunderstood, I wish to say that my statements are not to be interpreted as if I intended to declare silver wire to be less favourable for the cure of fistules than silk thread. I only hold that fine, well prepared silk thread is in no wise to be considered inferior to it (even when it remains during a long time in the tissues) and deserves preference on account of its being easier to apply. Any one who does not mind the greater trouble, the longer duration of the operation, which increases in proportion to the difficulty of the case, may use wire of metal.

[3]) To this class belong all the modifications which the followers of Sims, as Bozeman, Baker-Brown, Simpson etc. have invented. All these modifications are more complicated than the method of Sims and therefore can not be considered as improvements.

[4]) Neugebauer in Warsaw, Ulrich in Vienna and Bozeman in New-York have each invented apparatus and specula for the purpose of rendering operations of fistules practical without assistants. The one of Bozeman is handier than the others. In general I do not value them much, not only because they are not required, but because they are frequently quite insufficient and will not serve to expose fistules of difficult access; while on the other side the most inexperienced assistants, male or female, who can always be had, are able to hold the instruments I use. I have tried Bozeman's speculum repeatedly and have found that the fistula was always more easily laid open by means of my instruments and that fistules of difficult access could not be operated on at all by its aid.

it not only through the mucous membrane of the vagina, but also as far as that of the bladder and even through the same. The union I accomplish by a single row of silk sutures or in large defects by my double suture (one row to lessen the tension, the other to unite the borders of the wound). While the uniting sutures are invariably carried within the mucous membrane of the bladder, those intended to neutralize the tension may, as the size of the fistula requires, be carried to or through that membrane[1]). — Finally I have so simplified and improved the after-treatment, which used to be most troublesome for the surgeon and painful for the patient —, that all cause of complaint is removed for either, and every thing in the treatment is omitted, which hitherto was unfavourable to success. I mean to say, that I do not employ a catheter permanently for the purpose of removing the urine or to avoid movements of the bladder by its filling or discharging — but I leave the patients to discharge the urine, whenever they feel the want to do so, just as in days of perfect health. Only in those very rare cases in which the patients cannot pass the urine, as it occurs sometimes during the 24 hours following the operation, the catheter is employed, when the want is felt. Also in other respects the patient is permitted to behave as in days of health. The passage from the bowels is not kept back artificially; the patients can eat what they desire and can assume any position which may suit their comfort while lying in bed. Nor have I refrained from permitting them to leave their bed and to walk about, 24 hours after the operation, if their health otherwise was good. This „negative after-treatment," which was so opposed to that of the surgeons of other countries, I have recommended as early as 1860[2]) and in all my writings since then. I have based it upon observations, which on one hand proved the harmlessness of the urine, and of the movements of the bladder during its normal filling or discharging; and, on the other showed the disadvantages resulting from the permanent catheter, such as irritation, catarrh, spasm of the bladder, and its abnormal expansion if the catheter became accidentally obstructed[3]). The operation being terminated, which in favourable

[1]) See my work of 1854—1868 and particularly the treatises of 1862 and 1868, in which the advantages of this mode of freshening and making sutures are treated at length. According to the American method the mucous membrane of the bladder is to be avoided invariably, even in those cases where large defects are to be united.

[2]) See my article: „Bericht über 9 Fälle von Operationen der Blasenscheiden- und Blasen-Mutterscheidenfisteln etc." in „Scanzoni's Beiträge zur Geburtskunde und Gynäcologie," Würzburg 1860, Bd. IV, pag. 206; ferner meine citirten Schriften vom Jahre 1862 und 1868.

[3]) The priority of the after-treatment, without the permanent catheter, belongs undoubtedly to me. When, in 1860, I declared this treatment entirely rational and in 1862 pronounced it the only correct one, I met with a great deal of contradiction and only gradually have surgeons followed it. Nevertheless I expect soon to see it generally adopted, since not only myself but also other surgeons have attained the most favourable results by it. In Germany many surgeons make present use of it; in England Spencer Wells, to whom I sent my work of 1862, appears to have adopted it; in France Courty of

cases requires scarcely more than one hour, nothing more remains for the operator to do, in a majority of cases, than to remove the sutures. This is done after the 4th day, if the fistula is of easy access and, where this is difficult, after the 6th or 7th. It has happened that sutures have remained much longer (for several weeks), if, as it may occur, the ends were cut off close to the knots and thus became hidden in the tissues. No more trouble ever arose from this than if silver wire had been used.

Ever since I have operated with the means enumerated, in the manner described, and with the after-treatment above mentioned, the results of my fistula operations have become most satisfactory, more so perhaps than with any other operator. They present themselves as follows:

Old method.

1) At Darmstadt. From the year 1853 to 1859. (See my work of 1862, fol. 42).

Of 22 fistules in 22 patients

14 „ „ 14 „ were completely cured,

5 „ „ 5 „ were healed with the exception of small fistules; of these one patient, where Kolpokleisis had been attempted, was afterwards perfectly cured; an other one is now under treatment again,

1 patient with 1 fistula who was dismissed as incurable (is now again under my treatment),

2 patients with 2 fistules died.

Improved method.

2) At Darmstadt. From 1859 to spring 1861. (See my work of 1862, fol. 42).

Of 13 fistules in 13 patients

12 „ „ 12 „ were completely cured,

1 „ „ 1 „ was closed up to a small opening.

3) At Rostock. From spring 1861 to spring 1866. (See my work entitled „Beiträge zur plastischen Chirurgie," Prag 1868, fol. 141 & 142).

Of 53 fistules in 42 patients

49 „ „ 39 „ were completely cured,

2 „ „ 1 „ left unhealed,

2 „ died.

(Up to that date my results are published.)

late discontinued the use of the catheter. Also in America Dr. Schuppert of New-Orleans (see his work „vesico-vaginal fistula," New-Orleans 1866) has made an observation, which illustrates most strikingly the uselessness of the permanent catheter. He operated on a woman who could not remain in bed after the operation, being obliged to attend to her domestic duties; the fistula healed. It is singular that nevertheless Dr. Schuppert objects to this after-treatment without permanent catheter, (which erroneously he ascribes to Spencer Wells) and considers the cure a lucky accident, upon which one could not always rely. (See his work pag. 12 and 40).

To these are to be added:

4) At Rostock and Heidelberg: From spring 1866 to fall 1868.
Of 30 fistules in 28 patients,

28	„	„	26	„	were completely cured,
			2	„	died.

My results in toto[1]) are consequently the following:
Of 118 fistules which existed in 105 patients

104	„	„	„	„	92	„	were completely cured,
5	„	„	„	„	5	„	closed except small openings,
3	„	„	„	„	2	„	as incurable dismissed.
					6	„	died.

Thus in comparing the results of 1859 by the old imperfect method, with those attained after that year by means of the improved one, the proportion is considerably in favour of the latter. While previous to 1859 of 22 fistules only 14 (= 64%) were cured and 2 patients (= 9%) died, after that period, of 96 fistules which existed in 83 patients, 89 (= 92 2/3%) fistules in 77 patients were cured and only 4 patients (4 1/3%) died.

With what safety the cures are effected by my simplified method, the following report of my latest operations may serve to inform you, besides my works of 1862 and 1868 in which the results are given in detail. During 6 months residence at Heidelberg (from May to October 1868) we have operated on in the hospital 14 fistules in 14 patients. I have performed 12 and my assistants — Mess. Heine and Hotz — each one. Three of the fistules were very small; they had remained after previous operations at Rostock; the other 11 were new cases, but 6 of them had been operated already once or several times by other surgeons. Several of them were of considerable size; in 5 cases 12 sutures were required in order to close them, in one even 15. Moreover different complications existed, which made it necessary 3 times to embrace the posterior lip of the os uteri in the suture; once to overlap an existing atresia of the urethra; once to remove one; twice to perform Kolpokleisis and once to make a transplantation of a flap from the vulva. Yet, notwithstanding these troublesome circumstances, all 14 patients were cured by 17 operations. Of these 11 required only one operation; 3 had to be operated on twice each — among them were 2 small fistules which had remained from previous operations.

[1]) Of each of the published series some cases had remained under treatment, which only in later times were healed and were counted among the results then described. At present I have 3 patients, among whom 2 of the first series, under treatment, whose cure was not effected; it can only be accomplished by several operations, on account of the large size of the defects. In one of these cases I had tried Kolpokleisis, in the other one Episio-Elytrorrhaphy with imperfect success. I actually hope to close these defects by reestablishing the vesico-vaginal wall.

The majority of the patients left their beds on the 2nd or 3rd day and made even promenades on the „Hauptstrasse“ [1]); only in a few cases a slight fever ensued, which caused us to keep them longer in bed. On the 4th day the sutures were removed and 10 or 14 days after the operation the patients were dismissed. None of them suffered from catarrh of the bladder. The necessity of emptying the bladder was very frequent at first, because, as is easily complained, its capacity had become very much reduced, and admitted only a gradual increase. — But as further evidence of the superiority of the method, I deem it worth mentioning, that not only was I successful with it, but the two women, operated on by my assistants, were cured with equal promptness. Mr. Heine closed a small fistula by 4 sutures, Mr. Hotz performed Kolpokleisis by 13 sutures. The former case healed at once, the latter required only an unimportant operation to make the cure perfect. Mr. Heine had only once (before I came to Heidelberg) operated after an imperfect method and without success. Mr. Hotz had never operated on a fistula before.

After such results you will agree with me, esteemed colleague, that fine silk thread, which is much easier to apply than silver wire, is in no wise inferior to it and that the catheter in permanence is an unnecessary and even detrimental burden to the patient. And you will also feel yourself in justice bound to acknowledge, that the operation of vesico-vaginal fistula has reached in Germany a higher degree of simplicity, perfection and certainty of success than in any other country.

[1]) I permitted the patients to take walks, because I do not think walking detrimental and I could thus demonstrate to my pupils the uselessness of the permanent catheter and the harmlessness of movements. Generally the patients do remain in bed. But they can assume any position they like and only get up to discharge the urine. If they feel perfectly well otherwise and ask permission to get up, as it frequently happens, I grant their request.

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